

Nevada State Board of Medical Examiners 14-Day Sentinel Event Report Form

FOR OFFICIAL USE ONLY

Pursuant to NRS 630.30665, physician required to report within 14 days of occurrence, sentinel events occurring in-office or at other facilities NOT a medical facility as defined under NRS 449.0151 and/or NOT out of state.
SEND report to: NSBME, P.O. Box 7238, Reno, NV 89510-7238;
Fax: 775-688-2321; Email: nsbme@medboard.nv.gov.

PLEASE PRINT OR TYPE

Date of Sentinel Event: ___/___/___
MM DD Year

Date of Report: / /
MM DD Year

Patient's Nevada County of Residence: _____

Patient's State, or Country, of Residence (if Not Nevada): _____

Patient's Date of Birth: _____

Patient's Gender: Male Female

Did the sentinel event occur in a practice office: Yes No

If NO, in what type of facility did the sentinel event occur? (Do NOT report an event if it took place outside of Nevada or in a facility as defined under NRS 449.0151.)

What are the primary and secondary specialties of the physician performing the surgery or procedure?

DESCRIPTION OF SENTINEL EVENT

What was the surgery/procedure being performed? _____

Describe the sentinel event:

OUTCOME OF SENTINEL EVENT *(If death, actual physical injury with permanent loss or actual psychological injury with permanent loss occurred, please indicate.)*

Describe the Outcome:

CORRECTIVE ACTIONS *(If equipment repair or procedure, policy, or process modification or change took place, please indicate.)*

Corrective Action Taken:

SIGNATURE *(Please sign and date below. A separate Sentinel Event Report Form is required for each and every reportable sentinel event. A signature is required on each and every form.)*

Print Name: _____

License Number: _____

Office Address: _____

Doctor's Signature: _____

Date: _____